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Working With Your Older Patient: A Clinician's Handbook

National Institutes of Health
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Suggested Citation
Gastel, B. *Working with your older patient: A clinician's handbook.* Bethesda, MD: National Institute on Aging, National Institutes of Health, 1994.

Department of Health and Human Services

Foreword

As the population ages, clinicians are seeing more and more older patients, and they are seeing them with greater frequency. In 1991, older people averaged eight visits to a physician per year. Some researchers anticipate the number of physician visits by the growing population of people age 65 to 74 will nearly double between 1980 and 2040.

Care of older people offers special rewards and presents special challenges. One of these challenges is in the area of communication. What are the most effective ways to interact with older patients? How can difficult-to-discuss topics be broached? Are there some communication strategies that can help older patients who are experiencing confusion or memory loss? With these questions in mind, the National Institute on Aging (NIA), part of the National Institutes of Health, developed this handbook.

Facilitating Diagnosis and Promoting Adherence to Treatment

This handbook is aimed at two audiences. It offers physicians-in-training and other health care professionals an introduction to needed communication skills in dealing with older patients and their families, and it provides both a review and continuing education for more experienced clinicians. The handbook describes and explains issues pertinent to older patients, and

suggests practical techniques and approaches to facilitate diagnosis, promote adherence to treatment, make more efficient use of clinicians' time, and increase both patient and provider satisfaction. Written for NIA by Barbara Gastel, M.D., the manuscript has benefited from thoughtful reviews by physicians, nurses, social workers, and other health care professionals caring for older people.

It is important to make three points. First, while not intentionally ageist, clinicians may, without realizing it, allow societal stereotypes about aging to creep into everyday medicine. These attitudes do not reflect what research and practice tell us. For example, many physicians focus on the chronic nature of illness in older people and may be less vigilant about acute problems.

Second, these suggestions may at first glance appear time-consuming and difficult under current reimbursement systems. On closer reading, however, many of the approaches, such as detailed history-taking or testing for cognitive function, involve an initial investment of time that leads to a long-term gain for both patient and physician. There are several ways to implement these ideas to increase efficiency. You may, for instance, want to get to know your older patient over a few visits instead of trying to work everything into one session.

Finally, while this handbook presents some common themes about older patients, it is important to stress the diversity of aging America. The average doctor will see many healthy and independent older patients, as well as some who are frail. We hope that the techniques offered here encourage you to view older people as individuals, with a wide range of health care needs and questions.

Richard J. Hodes, M.D.
Director
National Institute on Aging

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"There's Still a Young Person Inside"

Older Patients' Perspectives

Older Americans are, if anything, a heterogeneous group. They vary widely in cultural background, educational level, economic status, health, and even chronological age. They bring a diversity of views, attitudes, experiences, and expectations to the medical encounter. A 68-year-old woman with an active consulting business is likely to deal with a visit to the doctor quite differently, and require a very different approach, than her frail 88-year-old aunt who has rarely ventured beyond the ethnic neighborhood where she has kept house all her adult life.

Nevertheless, the perspectives briefly discussed below are common enough among older people, and important enough to effective communication, that you should be especially aware of them.

Perceptions of Self

Like most of us, older people want to be viewed as individuals, not as stereotypical members of an age group. They want others to realize they were not always their current age, and may often feel "there's still a young person inside." Many older people do not view themselves as "old" in the pejorative sense, and they shun those safety measures and medical interventions they perceive as "only for old folks."

Views of Physicians

Some older people respect or even revere physicians. In general, because older people have mainly known physicians who were paternalistic rather than egalitarian, they expect a paternalistic approach. Many older people do not want to "waste the doctor's time" with concerns they fear the physician will deem unimportant, and they do not ask questions for fear of seeming to challenge the clinician. On the other hand, some older people, having ample time to read, will bring popular medical articles to the attention of their physicians. Try to avoid seeing this behavior as criticism.

Cultural Diversity

Some older members of ethnic minorities may be less assimilated into mainstream American culture than their younger counterparts. Paying special attention to the patient's cultural or ethnic heritage can help you tailor questions or treatment plans appropriately.

Older people whose native language is not English may be self-conscious about their fluency and could feel embarrassed when talking to physicians. Under the strain of illness, communicating in English could be especially difficult. An interpreter can help. Even if your older patients have always spoken English, those who are uneducated or who use regional dialects can be similarly uneasy.

Among many ethnic groups, strong extended families typically care for the elders and may participate in the patient's medical encounter. Understanding these cultural norms can help you plan appropriate care for the patient and provide support for family caregivers. The payoff may be better compliance.

Views About Aging and Health

Expectations regarding health diminish with age. This change is sometimes realistic. Often, though, older people with treatable symptoms dismiss problems as an inevitable part of aging and therefore do not seek medical care. As a result, they sometimes suffer needless discomfort and disability—and fail to receive treatment for serious conditions.

On the other hand, sometimes older people are disappointed because they used to "get better" or bounce back from an illness more quickly. They may feel frustrated that it takes longer to get their energy back.

Older people often do not report all their symptoms. This sometimes happens because they think aches and pains are a normal part of aging or, in some cases, because they are reluctant to "bother" the physician. It also can occur when a patient does not want to be seen as a hypochondriac or finds a topic (such as mental health, sexuality, or incontinence) embarrassing to discuss.

Patients may also be afraid of having their complaint dismissed or may worry that if they complain too much about small issues, they won't be taken seriously later on. Some older patients don't mention symptoms for fear of what the diagnosis or treatment might be. They may worry that the physician will recommend surgery, suggest costly diagnostic tests or medications, or tell them to stop driving or give up living alone. Sometimes they may feel a need to "save money for a rainier day."

Values Regarding Health

Although physicians typically focus primarily on diagnosing and treating disease, older people generally care most about maintaining the quality of their lives. Among their greatest fears are losing mental function (for example, through Alzheimer's disease), losing autonomy and independence, or being abandoned by family members.

Older people are not necessarily preoccupied with death. In fact, many older people have become relatively comfortable with the prospect of death and seek chiefly to make the most of their remaining years. Younger family members, who commonly must make life-and-death decisions when an older person is incapacitated, may be unaware of the patient's views about terminal care or may disagree with what the patient wants. It's a good idea to discuss the patient's wishes regarding this subject well before the information is likely to be needed. Ask about living wills or if advance directives have been prepared. It is also important to know if durable power of attorney for health care exists.

"Don't Call Me Edna"

Overcoming Communication Barriers

Certain attitudes about growing older and physical changes associated with aging can hinder communication between physicians and older patients. Many of these barriers can be reduced.

Alleviating Discomfort

A patient's physical or emotional discomfort can interfere with communication. Here are some suggestions to minimize common sources of such discomfort.

- Make the environment welcoming from the start. Be sure that the office is physically accessible. Also be sure that receptionists and other staff members treat the patient with warmth, consideration, and respect, both in person and over the telephone.

- Address the patient by his or her last name, using the title the patient prefers (for example, Mrs., Miss, Ms., Mr., Dr., Father, or Professor). Avoid forms of address such as "dear" or "hon," which tend to be impersonal and condescending. Address the patient by his or her first name only if the patient tells you to. Using the patient's last name conveys deference and promotes an atmosphere of equality. As one older patient quipped to her young physician, "Don't call me Edna, and I won't call you Sonny."

- Introduce yourself clearly. Show from the outset that you accept the patient and want to hear his or her concerns. You might mention looking forward to working together and encourage the patient to ask questions as they arise. If you are a consultant in a hospital setting, remember to explain your role or refresh the patient's memory of it.

- Keep the examining room warm enough, and check that the patient is otherwise physically comfortable.

- Avoid background noise and interruptions. They are especially disruptive if the patient has poor hearing or impaired cognition.

- Address the patient at eye level. For example, sit in a chair the same height as the patient's. This helps establish a comfortable atmosphere, and it allows the patient to pick up visual cues.

- Consider gently touching the patient on the hand, arm, or shoulder to help set him or her at ease. Some older people expect physicians to be "hands on," but be aware that this expectation may vary among cultures.

- Maintain an unhurried pace. Because many older people function well only if unrushed, trying to hurry communication can prove counterproductive. Some patients may need additional time to formulate their thoughts, so try not to put words in their mouths. To permit sufficient time, consider scheduling a longer visit or multiple visits.

Reducing Language Barriers

Language barriers can exist, whether or not a patient's native language is English. It can help to keep the following in mind.

- In addition to being unfamiliar with medical language (e.g., hypertension for high blood pressure, or gastric carcinoma for stomach cancer), older people may be unacquainted with recently coined words, new expressions, or new uses of old words. For example, an older patient may not know what it means to contact a support group or helpline, or to network with others. On the other hand, older patients may use expressions unfamiliar to younger clinicians. Use simple, common language and be willing to ask for clarification if needed.

- Educational levels of older people are generally lower than those of their children, and even some very intelligent older people may not be functionally literate. Keep this in mind when deciding whether to give written instructions. If an older person whose native language is not English lacks literacy in his or her native language, merely translating written materials will not suffice. Alternatives include using diagrams and giving written materials to relatives who read.

- Rapid-fire questioning and fast delivery of information may intimidate some older people. A gentle, more empathic style generally proves more comfortable and productive.

Compensating for Hearing Deficits

Hearing very often diminishes with age, and by age 79 an estimated 50 percent of people have significant hearing impairment. To compensate for hearing deficits you can use the following techniques.

- Early in the visit, remember to ask the patient whether he or she can hear you clearly. If possible, have an amplification device available in the office.

- If a patient without a known hearing disorder has trouble hearing you, examine the auditory canals for the presence of excess earwax.

- If the patient has a hearing aid, make sure that it works, that the patient knows how to use it, and that he or she is using it.

- Speak clearly. Face the patient, so he or she can lipread and pick up visual cues, and so you can see whether you are being understood. Be careful not to cover your mouth with your hand. Remember, if you have a mustache, the patient may not be able to read your lips.

- Speak in low tones as presbycusis diminishes hearing mainly in the higher range.

- Avoid shouting. Shouting distorts language sounds, is uncomfortable to the listener, and may inadvertently convey an impression of anger. In some medical settings very loud voices can be overheard by people other than the patient.

- Reinforce your speech through other channels such as gestures, simple diagrams, and written materials.

- Alert the patient when you change the subject. For example, pause briefly, speak a little more loudly, gesture toward what will be discussed, gently touch the patient, or ask a question.

- Check comprehension of what you have said. It's a good idea to ask the patient to repeat your main point in his or her own words.

Compensating for Visual Deficits

Visual disorders become more common with age. Difficulties presented by vision problems can be managed in several ways.

- Make sure the setting is adequately lighted and that there is sufficient light on your face. Try to minimize glare.

- Check that the patient has brought and is wearing his or her eyeglasses.

- Be aware that some older people can't bring objects into focus at close range. They may pull away so that they can see more clearly.

- Make sure that handwritten instructions are clear.

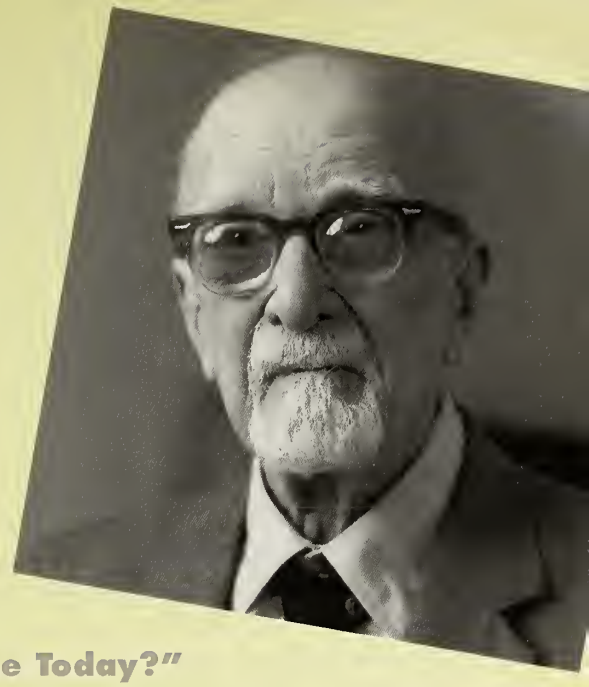
- When using printed materials for reinforcement, make sure the type is large enough and the typeface is easy to read. Printing such as the following tends to be widely suitable:

This size is readable.

- If the patient has trouble reading, consider alternatives such as tape-recording instructions, providing large pictures or diagrams, or using aids such as specially configured pillboxes.

Compensating for Cognitive Impairment

Temporary or ongoing cognitive impairment in older patients can pose especially challenging barriers to communication. These impairments can be the result of many disorders including strokes. For specific suggestions see page 29.



"What Led You to Come See Me Today?"

Obtaining the Medical History

When patients are older, obtaining a good history—of current concerns, family health experience, medications, and social situation—is crucial to sound health care. But doing so poses special challenges. The following ideas can aid in obtaining appropriate information with minimal strain on both you and the patient.

Although these suggestions may appear time-consuming, many of them involve a one-shot investment of time and can be performed by a variety of health care professionals in an office or home setting. You may also find it works best to schedule several short visits rather than trying to cover all these subjects at once.

General Suggestions

The varied nature and needs of older patients call for flexibility in interviewing. Here are some measures to consider.

- If feasible, gather preliminary data before the session. Request previous medical records, have the patient or family complete a questionnaire at home or in the waiting room, or obtain information from the patient by telephone. Structure questionnaires for easy reading by using large enough type and providing enough space between items. If questionnaires are to be filled out in the waiting room, keep them relatively short.

- Try to avoid making the patient tell his or her story more than once—first to a nurse and then to you. This can be tiring, especially if the patient has limited energy.

- Be willing to depart from the usual interview structure. You might understand the patient's condition more quickly if you elicit his or her past medical history immediately after the chief complaint, before obtaining a complete evaluation of the present illness.

- In the review of systems, remember to ask about often-overlooked problems, such as difficulty sleeping, incontinence, falling, depression, dizziness, or loss of energy.

- Pace the interview. An older patient may need extra time to formulate answers. Resist the tendency to interrupt prematurely.

- If the patient has trouble coping with open-ended questions, make greater use of yes-or-no or simple choice questions.

- Remember that the interview itself can be therapeutic. Although for you the patient is one of many, for the patient you may be one of the most important individuals in his or her life. The patient's chance to express concerns and to receive your attention can itself prove therapeutic.

Current Concerns

Although younger patients often have well-defined chief complaints reflecting classic presentation of single diseases, older patients tend to have multiple chronic conditions and show vague, atypical presentations of disorders. Thinking in terms of current concerns rather than a chief complaint may be more appropriate. Following are some considerations to keep in mind.

- Research shows that shortly after asking a patient his or her chief concerns, physicians commonly interrupt and turn to other matters. Try to resist this tendency and give the patient enough time to answer your questions.

- If a patient has ongoing problems that were discussed in previous visits, the temptation exists to begin by asking about them. Starting an interview with past concerns may leave the patient's

current concerns unarticulated until the end of the allotted time. Try beginning with general questions such as "How can I help you most at this visit?" or "What's been happening?"

- Encourage the patient and his or her caregivers to bring a list of their main concerns and questions to help ensure that these issues are discussed.

- Sometimes an older patient will see a physician because of concerns of family members or caregivers. Find out whose concern led to the visit.

- Even if a patient's chief concern is not the problem that is medically most important, you must deal with that concern. For example, an older patient may see you about a minor foot problem and be found to have dangerously high blood pressure or cognitive impairment. Only if the foot problem is addressed is the patient likely to follow your recommendations regarding blood pressure control or mental status testing.

- Symptoms in older people tend to be nonspecific, but the rate at which the symptoms develop can indicate whether an acute problem exists. Therefore, determine how fast the patient's condition has been changing.

- Sometimes a patient is not comfortable enough to express a concern, such as the death of a close relative or friend, until the end of an interview. To give such patients an opening, end with a question such as "Is there anything else you'd like to discuss?"

Medications

Side effects, interactions, and misuse of medications can lead to complications causing morbidity in older people. It is crucial to find out what medications older patients are using and how often they are taken. Older people often take many medications prescribed by several different doctors, e.g., general internists, cardiologists, urologists, or rheumatologists.

- Ask the patient to bring all the medications he or she is taking, both prescription and over-the-counter, to your office. A good approach is to have the patient put everything in a brown bag and bring it to each visit.

- Find out about the patient's habits of taking each medication. Ask what each one is for.

Family History

Even if the patient has passed the age at which many conditions with familial components typically appear, the family history can be of considerable value. It still indicates the patient's likelihood of developing some diseases, and it provides information on the health of relatives who care for the patient or who might do so in the future.

- The family history can offer a window of opportunity to explore the patient's experiences, perceptions, and attitudes regarding diseases and death. For example, a patient may say "I never want to be in a nursing home like my mother." Be alert for openings to discuss issues such as advance directives.

- It is important to obtain sufficient information not only on previous generations and siblings but also on children and grandchildren. If a patient needs long-term care at some point, you will know what support may be available from family members.

Life History

If you expect to continue caring for an older patient, obtaining a life history is an excellent investment of time. Obtaining such a history aids greatly in understanding the patient. It also strengthens the clinician-patient relationship by showing your interest in the patient as a person. Two suggestions:

- Use simple statements such as "Are you originally from this area?" to start a patient telling his or her life story.

- Be alert for information on the patient's relationships with others, thoughts about families or coworkers, typical responses to stress, and attitudes toward aging, illness, occupation, and death. Such information can help you interpret later reports by the patient and can help you make appropriate recommendations.

Functional Status

Knowing an older patient's usual level of functioning, and learning of recent changes in it, are basic to providing appropriate health care. You should remember:

- The ability to perform basic activities of daily living (ADLs) both reflects and affects a patient's health. It also influences which treatment regimens are suitable. Depending on the patient's status, ask about ADLs such as eating, bathing, and dressing and more complex instrumental activities of daily living (IADLs) such as cooking, shopping, and managing finances.

- Sudden changes in ADLs or IADLs are valuable diagnostic clues. In older people, serious conditions such as infections and infarctions often produce a decline in functional ability or confusion rather than symptoms such as fever or pain. If an older person stops eating, becomes confused or incontinent, or stops getting out of bed, look for underlying medical problems. Keep in mind the possibility the problem may be acute.

Social History

The social history also is crucial. If you are aware of the patient's living arrangements or access to transportation, you are much more likely to devise realistic, appropriate interventions.

- Ask about type of dwelling, neighborhood safety, eating habits, tobacco and alcohol use, typical daily activities, work, education, and financial situation. It also helps to find out who lives with or nearby the patient.

- Determine if the patient is a caregiver. Many older women care for spouses, elderly parents, or grandchildren. A patient's willingness to report symptoms sometimes depends on whether they think they can "afford to get sick."

A picture of the patient in his or her usual surroundings can be worth hours of interviewing. Thus, a home visit is often an excellent investment of time. However, make sure the patient understands the purpose of the visit. Here are some pointers.

- Remember to observe the patient's environment, mode of functioning, and interaction with others in the household. Your findings may aid greatly in diagnosis or treatment planning.

- If the patient offers to get you something to eat or drink, accept; how the patient proceeds can be very informative. A glimpse into the refrigerator may provide a wealth of information.

- If you cannot readily conduct a home visit yourself, consider sending a member of your staff. Nurses, social workers, and a range of other health care professionals can call on patients.

- If a home visit isn't possible, ask your patient to describe a typical day.

"Some People With This Condition . . . "

Exploring Sensitive Topics

Caring for an older patient requires discussing sensitive topics. Such discussions are sometimes more uncomfortable for the physician than for the patient. Some patients avoid mentioning their concerns because they think the physician would not want to discuss them. One way to show patients that sensitive issues are appropriate to address is to keep brochures and fact-sheets on these subjects in your waiting room.

The resources that follow represent a sampling of the kinds of information available. Refer to the NIA's *Resource Directory for Older People* (see page 25 for ordering information) for a more comprehensive list.

Sexuality

An understanding, accepting attitude and a sensitivity to verbal and other cues promote a comfortable, helpful discussion of sexuality. Depending on indications earlier in the interview, you may decide to approach the subject directly (for example, "Are you satisfied with your sex life?") or more obliquely, with allusions to changes that sometimes occur in marriage. Cues from the patient can then be followed up. You might note that many patients have a given concern, then wait for a response. Also effective are anecdotes about a person in a similar situation, or raising the issue in the context of physical findings (for example, "Some people taking this medication have trouble . . . Have you experienced anything like that?").

Don't assume that an older patient is no longer sexually active, does not care about sex, or necessarily is heterosexual.

More information about sexuality is available from:

Sex Information & Education Council of the United States
130 West 42nd Street, Suite 2500
New York, NY 10036
1-212-819-9770

Urinary Incontinence

About 10 million Americans, including 15 to 30 percent of community-dwelling people over age 65 and at least one-half of nursing home residents, have some significant degree of urinary incontinence. Often, this problem can be substantially alleviated through behavioral techniques such as bladder training.

Incontinence often goes untreated because the patient is embarrassed to mention it. You should ask specifically about the problem. Many physicians have found that the "some people" approach (for example, "when some people cough or sneeze, they tend to leak urine . . .") works well. Further information about urinary incontinence is available from:

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225/TTY 1-800-222-4225

Help for Incontinent People
P.O. Box 544
Union, SC 29379
1-800-252-3337 (1-800-BLADDER)

The Simon Foundation
P.O. Box 815
Wilmette, IL 60091
1-800-237-4666

Elder Abuse

An estimated one million or more older Americans each year are the victims of physical, psychological, or other forms of abuse. Embarrassment and fear of reprisal are some reasons

patients may not tell their physicians about this problem. Clues that elder abuse may be occurring include:

- Delay in seeking treatment for injuries, improbable explanations of injuries, or major inconsistencies between patient's and caregiver's accounts of how the patient was injured.

- Repeated injuries, suspicious-looking injuries, or signs of physical neglect.

- Changes in the patient's behavior when the caregiver enters or leaves the room.

- Risk factors such as substance abuse by a caregiver, a history of family violence, or exceptional stress on the caregiver.

If a patient appears to be at high risk, or if you suspect abuse or neglect, you should raise the possibility with the patient alone first. An opening to discuss the situation can be provided, for example, by noting that the caregiver is under the sort of stress that can make someone lose his or her temper.

If appropriate, you can help caregivers obtain the support needed to function appropriately or help them arrange for the patient to move to a new setting. As in discussing other sensitive topics, an understanding, constructive tone is needed. More information about elder abuse is available from:

National Aging Resource Center on Elder Abuse
810 First Street NE, Suite 500
Washington, DC 20002
1-202-682-2470

Depression

Although depression is by no means an inevitable part of aging, depressive symptoms and illness are common in older people and often can be treated. Signs of depression often go unrecognized. People who are depressed lack hope and may feel that reporting symptoms would be futile. And, because of the lingering stigma associated with mental illness and psychiatric treatment, some older people do not mention such problems. If clinicians are relatively unwilling to listen to older

people or believe that depression is simply a part of old age, the signs of depression are likely to be missed.

The patient's current and social history often provide clues that depression may be present. Look for aches and pains that just won't go away, irritability, problems with eating and weight, tiredness or lack of energy, or expressions of feeling "empty," sad, or anxious. Gently ask how the patient is doing and be direct in asking about sadness, tiredness, or episodes of crying. Try to ease fears about being evaluated by noting that a readily remediable cause may be found, such as a side effect of medications. If the patient is reluctant to be evaluated, relatives or friends of the patient may be able to provide reassurance. More information about depression in older people is available from:

NIMH Depression Awareness,
Recognition & Treatment Program
5600 Fishers Lane, Room 7C02
Rockville, MD 20857
1-800-421-4211

Long-Term Care

Although only 5 percent of the older population reside in nursing homes at any one time, about 43 percent of all people eventually spend some time in such a facility. Discussing the possibility of long-term care is often an important part of working with older patients. The topic should be explored with patients and caregivers early, so they can look into home care, daycare programs, nursing homes, or other options, well before the need arises.

You can begin talking about long-term care when discussing the course and management of the patient's medical problems. More information about long-term care is available from:

Administration on Aging
330 Independence Avenue SW
Washington, DC 20201
1-202-619-0641

American Association of Retired Persons
601 E Street NW
Washington, DC 20049
1-202-434-2277

Death and Terminal Care

Most older people have thought about the prospect of their death and want to discuss their wishes regarding terminal care. The opportunity to express these wishes can be provided at an appropriate time early in the physician-patient relationship, when the patient's values and history are being explored. Explain to the patient that because of new technologies and medical findings, great strides have been made in relieving pain, and it has become easier to manage the dying process. It may also be appropriate to bring up the issue of terminal care when meeting with family members and solicit their views on hospice care or advance directives.

You should make clear a willingness to resume the discussion about death and dying at other times and should keep alert for cues that the patient may want to talk about this again. Work with patients directly on advance directives and living wills to help ensure that they receive the type of care they want. These documents should be revised and updated based on patients' changing needs or desires. More information about terminal care is available from:

National Hospice Organization
1901 N. Moore Street, Suite 901
Arlington, VA 22209
1-800-658-8898

Cognitive Impairment

A major cause of cognitive impairment is Alzheimer's disease. For specific suggestions about communicating with patients with this illness, see page 29. However, many other disorders can cause similar memory loss, confusion, or related symptoms; for example, strokes—about 72 percent of stroke victims are age 65 or older. More information about strokes is available from:

National Stroke Association
8480 East Orchard Road, Suite 1000
Englewood, CO 80111-5015
1-800-367-1990

"Many People Believe . . ."

Educating the Patient

Most older patients are eager to understand their medical conditions and want to learn how to manage them. Likewise, family members and other caregivers want such information. Commonly, however, patients and caregivers feel that insufficient information has been supplied.

Research indicates that physicians typically underestimate how much patients want to know and overestimate how long they spend giving information to patients. Devoting more attention to educating patients may seem like a luxury, but in the long run it can improve patients' adherence to treatment, increase patients' well-being, and save the physician's time.

General Suggestions

The following general measures can help you inform patients and their caregivers about medical conditions and their treatment.

- Identify and discuss lifestyle factors such as diet and exercise that can facilitate or impede the patient's health.

- Although other members of the medical team can play key roles in educating patients and caregivers, what the physician says generally receives greatest credence. Therefore, begin by providing the main information and advice yourself. Other team members may then build on what you say.

- Some patients refrain from asking questions even if they want more information. Be aware of this tendency and make information available even if it is not requested.

- Encourage the patient to ask questions. Indicate who in addition to yourself can answer questions that arise later.

- Provide information through more than one channel. In addition to giving information orally, use or supply materials such as factsheets, drawings, models, videotapes, or audiotapes.

- Encourage the patient or caregiver to take notes and be ready to offer a pad and pencil. Active involvement in recording information may promote retention and compliance.

- Repeat key points, both within a given visit and at later visits.

- Present information in a way that is easy to understand. Avoid medical jargon, use simple everyday language, break the information into small parts, and use analogies or examples. Avoid overloading the patient with too much information at once.

- Check whether the patient and his or her caregivers understand what you say. One good approach is to ask that they repeat the main message in their own words.

- Provide praise and encouragement when appropriate. Call attention to strengths that can be built on. Remember to provide continued reinforcement for new treatment or lifestyle changes.

Explaining Diagnoses

Receiving clear explanations of diagnoses is critical. When patients do not understand their medical conditions, they tend not to follow the treatment plans. Uncertainty about what is wrong can be disturbing.

In explaining diagnoses, it is helpful to begin by finding out what the patient believes is wrong, what the patient sees as its implications, and how much more the patient wants to know.

You can use these responses as a starting point for gently correcting misconceptions (for example, "Many people believe . . . but actually we are learning that . . .") and providing appropriate amounts and types of information.

Discussing Treatment

Most treatment refusals by older patients result from the patients' feeling that they have received insufficient information. Remember that treatment can involve lifestyle changes (such as diet and exercise) as well as medication. Make sure you develop and communicate treatment plans carefully.

- Be certain that the patient agrees with the goal or outcome of the treatment plan.

- Keep the treatment plan as simple and straightforward as possible. For example, minimize the number of doses per day. Tailor the plan to the patient's situation and lifestyle, and try to reduce disruption to the patient's routine.

- After proposing a treatment plan, check with the patient about its feasibility and acceptability, and resolve any misunderstandings. For example, make it clear that a referral to another doctor does not mean you are abandoning the patient. If appropriate, revise the plan.

- Tell the patient what to expect from treatment or recommended lifestyle change, what improvement is realistic, and when he or she should start to feel better.

- Unless literacy is a problem, provide written instructions. Make sure the print is large enough for the patient to read.

- Indicate the purpose of each medication or other treatment.

- Make it clear which medications must be taken regularly and which ones the patient may choose to take only when having symptoms.

- Encourage the patient and his or her caregivers to take an active role in discovering how to manage chronic problems. Think in terms of joint problem-solving or collaborative care. Such an approach can increase both the patient's and his or her caregivers' satisfaction while decreasing demands on your time.

Recommending Resources

Many organizations and government agencies provide health-related information and services to older people and their caregivers. You can order these publications for the office library so they will be on hand to help your patients and conserve your time. Often a lack of ready information about other resources keeps physicians from referring patients to appropriate organizations or agencies.

In part to address this problem, the NIA makes available the *Resource Directory for Older People.* This directory contains names, addresses, and telephone numbers of more than 200 organizations offering health information, self-help programs, consumer advice, and other assistance. The NIA also publishes *Who? What? Where? Resources for Women's Health & Aging,* a directory providing an overview of the major health and lifestyle issues affecting older women and including selected readings and referral organizations. You may also find the Institute's *Age Page* series to be of use. These are factsheets with practical information on more than 40 topics of concern to older people. They are printed in large type and can readily be copied for distribution. Free copies of these publications are available by contacting:

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225/TTY 1-800-222-4225

"We Can Talk Together . . ."

Involving the Family and Others

Contrary to the common belief that families warehouse older relatives in nursing homes, the vast majority of older people have family members who care deeply about them and are active in promoting their well-being. Many older people also have close ties with friends, partners, neighbors, landlords, clergy, and others. Communicating effectively with these individuals and involving them in the older person's care can help your patient and make efficient use of medical resources.

Respecting the Patient

Maintaining the patient's privacy and autonomy, and yet involving others, can be a difficult balance. Here are some suggestions you may want to try:

- If possible, first see the patient alone. Have others join you, or meet separately with them, only after obtaining the patient's permission. If meeting with the patient first is not feasible, be sure to spend some time talking with the patient alone, perhaps during the physical examination.

- Be aware that three-party interactions tend to degenerate into "two against one." Avoid the tendency to "gang up" on the patient.

- When both the patient and others are present, address primarily the patient, if possible.

- Especially when a patient is very frail or has dementia, beware of a tendency to discuss him or her in the third person in his or her presence—or to act as if he or she was not present at all.

- If others want to shield an older patient from potentially painful information, explain to them the problems inherent in doing so.

Working With the Family and Others

To aid the family and others in working with the patient:

- Realize that some people want to help but are unsure how. Offer specific suggestions.

- Try to understand the group context. Learn about other demands on family members. Consider how to help integrate care of the patient.

- Foster a sense of collaboration. Make family members and others part of the older person's health care team.

- Ask the patient about other health care professionals he or she may be seeing. Remember to communicate sufficiently with the other health care providers or counselors seeing the patient.

Supporting Caregivers

Day-to-day care of a frail older person can be stressful, exhausting, and demoralizing. Through measures such as those listed below, you can support caregivers and contribute to your patient's well-being.

- Ask caregivers to identify the problems they find most distressing or disruptive, and work to address those problems.

- Remember that praise and encouragement from a physician can help sustain a caregiver.

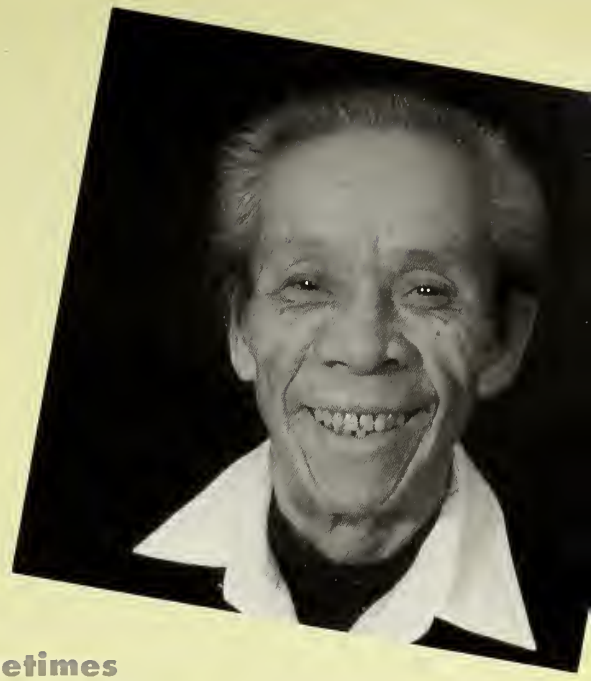
- To help keep stress from building up, encourage ongoing involvement of people other than the main caregivers.

- Recognize that a caregiver may need respite but feels guilty taking it. Recommending a vacation, or indicating that nursing home care may be the best option for all, can give the caregiver the permission needed to proceed.

The Administration on Aging supports a toll-free information line that can help family members or other caregivers identify local organizations for assistance. Call the Eldercare Locator at 1-800-677-1116.

Information about caregiving is also available from:

Children of Aging Parents
1609 Woodbourne Road, Suite 302-A
Levittown, PA 19057
1-215-945-6900



"You Mentioned Sometimes Having Trouble With Memory"

The Confused Patient

Although the vast majority of older people show very little or no decrease in cognitive function, dementing disorders such as Alzheimer's disease do become more common with age. Thus, as the oldest segments of the population continue to grow, clinicians can expect to see more and more patients with these disorders. Also, in later life various illnesses, both physical and mental, can cause temporary, reversible cognitive impairment. The diagnosis of Alzheimer's disease remains largely one of exclusion.

The general measures presented throughout this handbook can aid in working with cognitively impaired older people and their caregivers. The following suggestions pertain specifically to the confused patient.

The NIA-funded Alzheimer's Disease Education and Referral Center (ADEAR) can provide you with information about Alzheimer's disease. Call or write:

ADEAR
P.O. Box 8250
Silver Spring, MD 20907-8250
1-800-438-4380

Communicating With the Patient

When working with a confused patient:

- Check for clouded consciousness, delirium, slurred speech, or other signs. Remember that the patient's behavior could be the result of a stroke.

- Remember to orient the patient. Explain (or re-explain) who you are and what you will be doing. If possible, meet in surroundings familiar to the patient. Consider having a family member or other familiar person present.

- Support and reassure the patient. Acknowledge when responses are correct. If the patient gropes for a word, gently provide assistance. Make it clear that the encounter is not a "test," but rather a search for information to help the patient.

- Use simple, direct wording. Present one question, instruction, or statement at a time.

- If the patient hears you but does not understand you, rephrase your statement.

- Although open-ended questions are advisable in most interview situations, patients with cognitive impairment often have difficulty coping with them. Consider using a yes-or-no or multiple-choice format.

- If the patient can read, provide instructions in writing.

- Have a staff member call to remind the patient of appointments. Perhaps advise the patient to bring a family member or caregiver along.

- Consider having someone call the patient to follow up on instructions after outpatient visits.

Assessing Mental Status

Although assessing an older person's cognitive function is important, formal testing of mental status tends to be anxiety-provoking for the patient. Often, information about the patient's mental state is revealed during the medical history. Information also can be gleaned from the patient's behavior

on arrival in the medical setting, or from interactions with staff by telephone before the visit. Family members who may contact you in advance of the visit are also a source of information.

Formal testing of mental status often is best left until the latter part of the session—either between the history and the physical examination or after the examination. The testing may then be presented in the context of concerns the patient has expressed. ("You mentioned sometimes having trouble with memory. Let's try to find out more about that.") Providing support and encouragement during the testing can decrease the stress. ("Some of these questions are hard, so just do the best you can.")

Although there are limitations to any mental status test—for example, the test can reflect level of education or the results may appear normal early in the disease—many clinicians find the Mini-Mental State Examination (Folstein, Folstein, and McHugh, 1975) helpful. For easy reference, a card containing this test is included at the back of this handbook.

Conveying Findings

Often, assessment of mental status shows no significant impairment. If a patient has voiced concern about his or her mental functioning, he or she may continue to worry unless substantial reassurance is provided. Emphasize that occasional trouble remembering information such as names is fairly common among older people and does not mean there is a serious impairment. Encourage the use of notes or reminders.

When cognitive impairment is found in an older person, it may reflect a variety of conditions, many of them reversible. Possibilities to be alert for include stroke, medication effects, infections, endocrine disorders, dehydration, subdural hematomas, normal pressure hydrocephalus, residual effects of anesthesia, and serious depression or other affective disorders. Since patients or caregivers may assume that the cause is Alzheimer's disease, you may need to explain the need for a careful history and physical examination to search for reversible conditions.

If Alzheimer's disease appears to be present, the question arises of what to tell the patient. The answer depends on what the patient wants to know and how well the patient's mind is working. You might consider, "You have a memory disorder, and I believe it will get worse as time goes on. It's not your fault. It may not help for you to try harder. You need to go ahead and make whatever plans are necessary before your memory gets worse."

Receiving a diagnosis relatively early, while cognition is still fairly intact, can allow a patient to make financial plans, prepare advance directives, and express informed consent for research. Sometimes the patient is relieved to know the nature of his or her problem. Disadvantages of telling a patient the diagnosis include potential stigmatization and the possibility of adverse emotional reactions.

Informing family members or others that the patient seems to have Alzheimer's disease often is best done in a family conference or group meeting, which should be arranged with the consent of the patient. In some situations, a series of short visits may be more suitable. You should make clear your ongoing availability for care, information, guidance, and support.

Working With Caregivers

When a patient has Alzheimer's disease or a related disorder, you can help all concerned by working effectively with caregivers and other members of the family or household. In addition to the general measures for supporting caregivers, the following can help.

- Explain that much can be done to improve the patient's quality of life. Various measures—such as modifications in daily routine, adaptations of the environment, reassurance, appropriate cues, and medications for anxiety, depression, or sleep—may help control symptoms.

- Let the caregivers know there is time to adapt. Decline is rarely rapid.

- Provide caregivers with information about the consumer resources and support services available from:

Alzheimer's Association
919 N. Michigan Avenue, Suite 1000
Chicago, IL 60611
1-800-272-3900

- Help caregivers and others to plan ahead for the possibility of needing more help at home or having to look into residential care.

- Emphasize the need—and help find ways—for caregivers to get adequate nutrition, exercise, rest, and stimulation.

- Persuade caregivers to get respite regularly, especially when patients have required constant attention. ("You need to keep taking a few hours for yourself so you'll be able to provide care the rest of the time" or "Wouldn't you want her to take care of herself if your roles were reversed?")

- Listen to caregivers' concerns and acknowledge their efforts. ("Your mother may not be able to express her gratitude, but I know what it takes to keep her looking so good.")

- Ask if the caregiver, who is at considerable risk for stress-related disorders, is receiving adequate health care.

- When appropriate, recommend a support group, reading materials, or counseling.

- Encourage caregivers and others to maintain their sense of humor and to recognize the joys remaining in life.

Keeping the Door Open

Ongoing Communication

Ongoing communication is key to working effectively with the older patient. If a patient does not follow recommendations or starts missing appointments, explore whether a difficulty in communication has developed. Scheduling occasional appointments, even when an older person's health problems seem inactive, may aid in maintaining open communication. Return phone calls promptly. If the patient can't get to the office, offer to help over the phone if possible.

The best way to promote ongoing communication is to communicate well from the start. The suggestions that have been presented in this handbook can help in doing so. The results: a healthier older patient and greater satisfaction for patient and clinician alike.

Resource List

For easy reference, a variety of resources are listed below, along with the telephone numbers to call for information and publications. Additional relevant organizations are listed in the NIA's *Resource Directory for Older People.*

Organization	*Phone Number*
Administration on Aging	1-202-401-4541
Alzheimer's Association	1-800-272-3900
Alzheimer's Disease Education and Referral Center	1-800-438-4380
American Association of Retired Persons	1-202-434-2277
Children of Aging Parents	1-215-945-6900
Eldercare Locator	1-800-677-1116
Help for Incontinent People	1-800-BLADDER
National Aging Resource Center on Elder Abuse	1-202-682-2470

National Cancer Institute.....1-800-4-CANCER

National Hospice Organization 1-800-658-8898

NIMH Depression Awareness,
Recognition and Treatment Program.....1-800-421-4211

National Institute on Aging
Information Center.....1-800-222-2225

National Stroke Association.....1-800-367-1990

Sex Information & Education
Council of the United States 1-212-819-9770

The Simon Foundation.....1-800-237-4666

Recommended Readings

For further information on communicating with older patients, you may find the following readings helpful. In addition, a paper and annotated bibliography on this subject, written by Analee E. Beisecker, Ph.D., University of Kansas Medical Center, is available from the NIA. To obtain copies of "Older Patients and Their Doctor" contact the NIA at 1-800-222-2225/ TTY 1-800-222-4225.

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Drickamer MA, Lachs MS. Should patients with Alzheimer's disease be told their diagnosis? *New England Journal of Medicine* 1992 April 2; 326(14): 947-951.

Eisdorfer C, Rabins PV, Reisberg B. Alzheimer's disease: Caring for the caregiver. *Patient Care* 1991 November 15; 25(18): 109-116, 121-123.

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Haug MR, Ory MG. Issues in elderly patient-provider interactions. *Research on Aging* 1987; 9(1): 3-44.

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Mader SL, Ford AB. History and physical examination of the geriatric patient. In: Calkins E, Ford AB, Katz PR, editors. *Practice of Geriatrics.* 2nd ed. Philadelphia: Saunders, 1992, pp. 101-109.

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A Call for Su

Please se
ences, or

Freddi Ka
Public Inj
National
Building
Bethesda,
1-301-49

LIBR
NIH
Amazing
Amazing
http://nihlibrary.nih
10 Center Drive
Bethesda, MD 20892
301-496-1080

Mini-Mental State Examination

Give one point for each correct response

		Score	Points
Orientation			
1. What is the	Year	_____	1
	Season	_____	1
	Date	_____	1
	Day	_____	1
	Month	_____	1
2. Where are we?	State	_____	1
	County	_____	1
	Town or city	_____	1
	Hospital/nursing home/other building	_____	1
	Floor	_____	1
Registration			
3. Name three objects, taking 1 second to say each. Then ask the patient to repeat all three. (Give one point for each correct answer. Repeat the answers until the patient learns all three.)		_____	3
Attention and Calculation			
4. Serial sevens: Ask the patient to count backwards from 100 by sevens, as 93, 86, 79, etc. (Stop after five answers; give one point for each correct answer.) Alternative: Spell WORLD backwards.		_____	5
Recall			
5. Ask for names of the three objects learned in question 3. (Give one point for each correct answer.)		_____	3
Language			
6. Point to a pencil and a watch. Ask the patient to name each as you point.		_____	2
7. Ask the patient to repeat "No ifs, ands, or buts."		_____	1
Page 1 Subtotal		_____	24

A Call for Suggestions

Please send comments, personal observations, practical experiences, or suggestions to:

Freddi Karp, Editor
Public Information Office
National Institute on Aging
Building 31, Room 5C27
Bethesda, MD 20892
1-301-496-1752

LIBRARY
NIH
Amazing Research.
Amazing Help.
http://nihlibrary.nih.gov
10 Center Drive
Bethesda, MD 20892-1150
301-496-1080

D., gratefully acknowledges the help of her fellow others who shared their observations, insights, her during this handook's preparation. She also for their additions.

8. Ask the patient to follow a three-stage command: "Take a paper in your right hand. Fold the paper in half. Put the paper on the floor."	____	3
9. Ask the patient to read and obey the following command: "CLOSE YOUR EYES." (Write in large letters.)	____	1
10. Ask the patient to write a sentence of his or her choice. (The sentence should contain a subject and an object and should make sense. Ignore spelling errors when scoring.)	____	1
11. Ask the patient to copy the design shown. (Give one point if all sides and angles are preserved and if the intersecting sides form a quadrangle.)	____	1
Page 2 Subtotal	____	6
Add Page 1 Subtotal	____	24
TOTAL SCORE	____	30

The Mini-Mental State Examination, which can be administered in the primary care setting in about 10 minutes. will accurately identify patients who have cognitive impairment. A score of 20-24 generally suggests mild impairment; a score of 16-19, moderate impairment: and a score of 15 or less, severe deficit. Keeping track of a patient's scores over time will also document progression of the patient's dementing disease.

Reprinted from Folstein MF, Folstein SE, McHugh PR: "Mini-Mental State" [illegible] method for grading the cognitive state of patients for the clinician. [illegible] 12:189-198. Copyright 1975, with kind permission from Pergamon Press [illegible] Hill Hall, Oxford OX3 OBW, UK.

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Department of Health and Human Services
Public Health Service, National Institutes of Health
NIH Publication Number 93-3453
June 1994